



Fax to:
GROUP LOCKHART INC.
Fax No. 519-673-6657
Phone No. 1-800-265-1224

MANULIFE HOSPITALITY BENEFIT PROGRAM
QUESTIONNAIRE - PAGE 1 OF 3

NAME OF COMPANY: _____

ADDRESS: _____

PROVINCE: _____

POSTAL CODE: _____

PHONE #: _____

FAX #: _____

CONTACT NAME: _____

TITLE: _____

ASSOCIATION MEMBERSHP NUMBER#: _____

YEARS IN BUSINESS (Minimum 1 year): _____

OF EMPLOYEES: _____

CHECK THE FOLLOWING BENEFITS CURRENTLY IN PLACE

EIC: _____ CPP: _____ WCB: _____

ARE YOU CURRENTLY PROVIDING A BENEFIT PLAN:

YES: _____ NO: _____

ARE YOU CURRENTLY PROVIDING GROUP RRSP:

YES: _____ NO: _____

*If you have answered **YES** to any of the above please complete the following information:

NAME OF INSURANCE COMPANY: _____

RENEWAL DATE: _____

ADDITIONAL COMMENTS:



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 (To be completed in FULL for ALL quotations.)
 2 - 10 LIVES

NAME OF COMPANY: _____

BENEFIT OPTIONS

LIFE & ACCIDENTAL DEATH & DISMEMBERMENT:

\$25,000 Flat: _____ \$50,000 Flat: _____ 1x Annual: _____ 2x Annual: _____

DEPENDENT LIFE:

DEP1: SPOUSE \$10,000/CHILD \$5,000 _____ DEP2: SPOUSE \$5,000/CHILD \$2,500 _____

LONG TERM DISABILITY (Management Only):

2 Year: _____ To Age 65: _____ (120 Day Elimination Period)

EXTENDED HEALTH:

EHC1: 0/0/100% _____

EHC2*: 0/0/80% _____

EHC3: \$25/\$50/100% _____

(Above 3 Options Include \$100/24 month Vision Care)

EHC4: 0/0/100% _____

EHC5*: 0/0/80% _____

EHC6: \$25/\$50/100% _____

(Above 3 Options Include \$200/24 month Vision Care)

DENTAL COVERAGE:

DEN1: 0/0/100% _____

DEN2*: 0/0/80% _____

DEN3: \$25/\$50/100% _____

DEN4*: \$25/\$50/80% _____

****IF NO COVERAGE CURRENTLY GROUPS ARE LIMITED TO 80% CO-INSURANCE***

***ELIGIBILITY: Applicants must be under age 65 with 3 months of service
 and working a minimum of 25 hours per week***

FOR QUESTIONS PLEASE CONTACT: 1-800-265-1224



HOSPITALITY BENEFIT PROGRAM

Administered by Group Lockhart

195 Dufferin Avenue, Suite 450, London, Ontario, N6A 1K7

Fax: 519-673-6657 Telephone: 519-672-3890

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Employee I.D.	Salary	Salary Type *	Sex	Dependent Status (S)(F)	Date of Birth (dd/mm/yy)	Prov.	Job Title	Class	EHC S, F, N/A	Dental S, F, N/A	Employment Date (dd/mm/yy)	Currently Disabled (Y/N)
1												
2												
3												
4												
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The purpose for which this information is being gathered is to confirm employment, date of birth and salary information in order to provide an accurate quotation for employee benefit programs.

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* Salary Type – Please indicate: H – Hourly, W – Weekly, B – Bi-weekly, M – Monthly, Y – Yearly